FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041737

Facility Name: Provena St Anne Center

Address: 4405 Highcrest Road (Number) Rockford (City) 61107 (Zip Code)

County: Winnebago

Telephone Number: (815) 299-1999 **Fax #** (815) 299-1560

IDPA ID Number: 371127787010

Date of Initial License for Current Owners: 10/6/86

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code 501 C3

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** (708) 478-7916

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Michael R. Gordon

(Title) VP of Finance, CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	179	TOTALS	179	65,335	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,577		18,348	38,925	8
9	SNF/PED					9
10	ICF		20,754		20,754	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,577	20,754	18,348	59,679	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.34%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/6/86

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 119 and days of care provided 18,348

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	409,154	72,871	23,454	505,479		505,479		505,479			1
2	Food Purchase		327,169		327,169		327,169	3,458	330,627			2
3	Housekeeping	139,797	24,286	50	164,133		164,133		164,133			3
4	Laundry	20,849	6,237	128,755	155,841		155,841		155,841			4
5	Heat and Other Utilities			169,307	169,307		169,307	1,920	171,227			5
6	Maintenance	128,207	29,672	48,268	206,147		206,147	53,866	260,013			6
7	Other (specify):* **Pastoral Care**	38,589	1,182	15,535	55,306		55,306	(3,233)	52,073			7
8	**TOTAL General Services**	736,596	461,417	385,369	1,583,382		1,583,382	56,011	1,639,393			8
	B. Health Care and Programs											
9	Medical Director			19,200	19,200		19,200		19,200			9
10	Nursing and Medical Records	3,989,834	392,912	347,445	4,730,191		4,730,191		4,730,191			10
10a	Therapy			929,925	929,925		929,925		929,925			10a
11	Activities	101,337	1,319	9,148	111,804		111,804	2,105	113,909			11
12	Social Services	102,653	20	354	103,027		103,027		103,027			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,193,824	394,251	1,306,072	5,894,147		5,894,147	2,105	5,896,252			16
	C. General Administration											
17	Administrative	336,756	58,911	874,800	1,270,467		1,270,467	(418,573)	851,894			17
18	Directors Fees											18
19	Professional Services			60,263	60,263		60,263	307,679	367,942			19
20	Dues, Fees, Subscriptions & Promotions			113,403	113,403		113,403	(56,954)	56,449			20
21	Clerical & General Office Expenses			198,883	198,883		198,883	(11,357)	187,526			21
22	Employee Benefits & Payroll Taxes			1,000,562	1,000,562		1,000,562	151,287	1,151,849			22
23	Inservice Training & Education			7,393	7,393		7,393	6,445	13,838			23
24	Travel and Seminar			17,675	17,675		17,675	7,198	24,873			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			128,485	128,485		128,485	7,733	136,218			26
27	Other (specify):* **Bad Debt**			20,912	20,912		20,912	(20,912)				27
28	**TOTAL General Administration**	336,756	58,911	2,422,376	2,818,043		2,818,043	(27,454)	2,790,589			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,267,176	914,579	4,113,817	10,295,572		10,295,572	30,662	10,326,234			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Provena St Anne Center #0041737 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			319,404	319,404		319,404	108,792	428,196			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							213,526	213,526			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							19,310	19,310			34
35	Rent-Equipment & Vehicles			7,400	7,400		7,400	1,023	8,423			35
36	Other (specify):*											36
37	**TOTAL Ownership**			326,804	326,804		326,804	342,651	669,455			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,003,927	1,003,927		1,003,927		1,003,927			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,271	98,271		98,271		98,271			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			1,102,198	1,102,198		1,102,198		1,102,198			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,267,176	914,579	5,542,819	11,724,574		11,724,574	373,313	12,097,887			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,046	30		9
10	Interest and Other Investment Income	(10,115)	32		10
11	Discounts, Allowances, Rebates & Refunds	(26,615)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,912)	27		24
25	Fund Raising, Advertising and Promotional	(68,457)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (112,053)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	488,599		34
35	Other- Attach Schedule	(3,233)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 485,366		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 373,313		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Provena St Anne Center

ID# **0041737**

Report Period Beginning: **01/01/05**

Ending: **12/31/05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Misc	$ (3,233)	7	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,233)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Provena St Anne Center # 0041737 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	3,458	0	0	0	0	0	0	0	0	0	3,458	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,920	0	0	0	0	0	0	0	0	0	1,920	5
6	Maintenance	0	674	53,192	0	0	0	0	0	0	0	0	53,866	6
7	Other (specify):*	(3,233)	0	0	0	0	0	0	0	0	0	0	(3,233)	7
8	**TOTAL General Services**	(3,233)	6,052	53,192	0	0	0	0	0	0	0	0	56,011	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,105	0	0	0	0	0	0	0	0	0	2,105	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	2,105	0	0	0	0	0	0	0	0	0	2,105	16
	C. General Administration													
17	Administrative	0	(387,665)	(30,908)	0	0	0	0	0	0	0	0	(418,573)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	38,607	269,072	0	0	0	0	0	0	0	0	307,679	19
20	Fees, Subscriptions & Promotions	(68,457)	11,503	0	0	0	0	0	0	0	0	0	(56,954)	20
21	Clerical & General Office Expenses	(26,615)	15,258	0	0	0	0	0	0	0	0	0	(11,357)	21
22	Employee Benefits & Payroll Taxes	0	61,853	89,434	0	0	0	0	0	0	0	0	151,287	22
23	Inservice Training & Education	0	6,445	0	0	0	0	0	0	0	0	0	6,445	23
24	Travel and Seminar	0	7,198	0	0	0	0	0	0	0	0	0	7,198	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	7,733	0	0	0	0	0	0	0	0	0	7,733	26
27	Other (specify):*	(20,912)	0	0	0	0	0	0	0	0	0	0	(20,912)	27
28	**TOTAL General Administration**	(115,984)	(239,068)	327,598	0	0	0	0	0	0	0	0	(27,454)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(119,217)	(230,911)	380,790	0	0	0	0	0	0	0	0	30,662	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Provena St Anne Center** **#** **0041737** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	14,046	0	94,746	0	0	0	0	0	0	0	0	108,792	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,115)	0	223,641	0	0	0	0	0	0	0	0	213,526	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	19,310	0	0	0	0	0	0	0	0	19,310	34
35	Rent-Equipment & Vehicles	0	0	1,023	0	0	0	0	0	0	0	0	1,023	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,931	0	338,720	0	0	0	0	0	0	0	0	342,651	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(115,286)	(230,911)	719,510	0	0	0	0	0	0	0	0	373,313	45

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Provena Senior Services	100.00%	$ 3,458	$ 3,458	1
2	V	5	Utilities		Provena Senior Services	100.00%	1,920	1,920	2
3	V	6	Maintenance - Other		Provena Senior Services	100.00%	674	674	3
4	V	11	Activities-Special Events		Provena Senior Services	100.00%	2,105	2,105	4
5	V	17	Admin - Misc. Other	630,000	Provena Senior Services	100.00%	18,036	(611,964)	5
6	V	17	Administrative Salaries		Provena Senior Services	100.00%	224,299	224,299	6
7	V	19	Professional Services		Provena Senior Services	100.00%	38,607	38,607	7
8	V	20	Dues,Subscriptions		Provena Senior Services	100.00%	11,503	11,503	8
9	V	21	Clerical Supplies		Provena Senior Services	100.00%	15,258	15,258	9
10	V	22	Employee Benefits		Provena Senior Services	100.00%	61,853	61,853	10
11	V	23	Education/Conference		Provena Senior Services	100.00%	6,445	6,445	11
12	V	24	Travel		Provena Senior Services	100.00%	7,198	7,198	12
13	V	26	Insurance		Provena Senior Services	100.00%	7,733	7,733	13
14	Total			$ 630,000			$ 399,089	$ * (230,911)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Provena Senior Services	100.00%	$ 3,667	$ 3,667	15
16	V	32	Interest		Provena Senior Services	100.00%	223,641	223,641	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	19,310	19,310	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	1,023	1,023	18
19	V	17	Admin Salaries	145,200	Provena Health Services	100.00%	95,478	(49,722)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	39,922	39,922	20
21	V	30	Depreciation		Provena Health Services	100.00%	91,079	91,079	21
22	V	19	Admin Consulting,Other		Provena Health Services	100.00%	269,072	269,072	22
23	V	17	Information Systems Salaries	99,600	Provena Health Services	100.00%	21,518	(78,082)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	8,997	8,997	24
25	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	9,598	9,598	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	59,589	59,589	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	24,916	24,916	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	37,307	37,307	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	15,599	15,599	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	43,594	43,594	30
31	V	39	Ancillary Services - Other	1,003,927	Provena Senior Services Pharmacy	100.00%	1,003,927		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,248,727			$ 1,968,237	$ * 719,510	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	5,261,654	20	$ 28,878	$	630,000	$ 3,458	1
2	5	Utilities	Management Fee Income	5,261,654	20	16,037		630,000	1,920	2
3	6	Maintenance - Other	Management Fee Income	5,261,654	20	5,629		630,000	674	3
4	11	Activities-Special Events	Management Fee Income	5,261,654	20	17,583		630,000	2,105	4
5	17	Admin - Misc. Other	Management Fee Income	5,261,654	20	150,633		630,000	18,036	5
6	17	Administrative Salaries	Management Fee Income	5,261,654	20	1,873,311	1,873,311	630,000	224,299	6
7	19	Professional Services	Management Fee Income	5,261,654	20	322,442		630,000	38,607	7
8	20	Dues,Subscriptions	Management Fee Income	5,261,654	20	96,069		630,000	11,503	8
9	21	Clerical Supplies	Management Fee Income	5,261,654	20	127,431		630,000	15,258	9
10	22	Employee Benefits	Management Fee Income	5,261,654	20	516,585		630,000	61,853	10
11	23	Education/Conference	Management Fee Income	5,261,654	20	53,828		630,000	6,445	11
12	24	Travel	Management Fee Income	5,261,654	20	60,116		630,000	7,198	12
13	26	Insurance	Management Fee Income	5,261,654	20	64,582		630,000	7,733	13
14	30	Depreciation	Management Fee Income	5,261,654	20	30,629		630,000	3,667	14
15	32	Interest	Management Fee Income	5,261,654	20	1,867,812		630,000	223,641	15
16	34	Rent - Facility	Management Fee Income	5,261,654	20	161,270		630,000	19,310	16
17	35	Rent - Equipment	Management Fee Income	5,261,654	20	8,543		630,000	1,023	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,401,378	$ 1,873,311		$ 646,730	25

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Health Services
Street Address: 9223 West St. Francis Road
City / State / Zip Code: Frankfort, IL 60423
Phone Number: (815)469-4888
Fax Number: (815)469-4864

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	1,146,264	10	$ 753,738	$ 753,738	145,200	$ 95,478	1
2	22	Employee Benefits	Operating Expense	1,146,264	10	315,161		145,200	39,922	2
3	30	Depreciation	Operating Expense	1,146,264	10	719,013		145,200	91,079	3
4	19	Admin Consulting,Other	Operating Expense	1,146,264	10	2,124,158		145,200	269,072	4
5	17	Information Systems Salaries	Operating Expense	791,616	10	171,021	171,021	99,600	21,518	5
6	22	Information Systems Benefits	Operating Expense	791,616	10	71,509		99,600	8,997	6
7	6	Information Systems - Equip Mair	Operating Expense	791,616	10	76,287		99,600	9,598	7
8	17	Admin Salaries	Direct Cost	1,146,264	10	470,416	470,416	145,200	59,589	8
9	22	Employee Benefits	Direct Cost	1,146,264	10	196,696		145,200	24,916	9
10	17	Information Systems Salaries	Direct Cost	791,616	10	296,512	296,512	99,600	37,307	10
11	22	Information Systems Benefits	Direct Cost	791,616	10	123,981		99,600	15,599	11
12	6	Information Systems - Equip Mair	Direct Cost	791,616	10	346,486		99,600	43,594	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,664,978	$ 1,691,687		$ 716,669	25

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services Pharmacy
Street Address: 1475 Harvard Drive
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 1,003,927	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,003,927	25

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Provena Senior Services										213,526	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 213,526	14
15	TOTALS (line 9+line14)						$	$			$ 213,526	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Provena St Anne Center # 0041737 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	**8**
	2001	**9**
	2002	**10**
	2003	**11**
	2004	**12**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena St Anne Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0041737

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	facility		1985	$ 645,354	1
2					2
3	TOTALS			$ 645,354	3

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1986	$ 3,516,907	$ 100,483	35	$ 100,483	$	$ 2,037,798	4
5	59			1992	2,722,251	90,742	10	90,742		1,125,963	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	3,173	127	25	127		2,284	9
10	Various			1990	36,288	1,122	15	1,122		18,896	10
11	Various			1991	30,799		10			30,799	11
12	Various			1992	10,277		10			10,277	12
13	Various			1993	8,128		10			8,128	13
14	Various			1994	7,032		10			7,032	14
15	Various			1995	43,992	2,121	14	2,121		24,505	15
16	Various			1996	27,087	1,940	9	1,940		23,442	16
17	Various			1997	90,989	3,380	6	3,380		79,992	17
18	Various			1998	51,201		5			51,207	18
19	Various			1999	19,372	60	5	60		19,162	19
20	Various			2000	61,109	6,236	5	6,236		55,474	20
21	Various			2001	347,808	36,428	5	36,428		167,292	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DESC: PAINT WALLS - HANG WALLPAPER	2002	$ 1,936	$ 387	5	$ 387	$	$ 1,355	37
38	DESC: CANOPY FOR WEST UNIT	2002	3,760	251	15	251		877	38
39	DESC: WEST UNIT AWNING	2002	3,085	206	15	206		720	39
40	DESC: TAPESTRY FOR LOBBY	2002	850	170	5	170		595	40
41	DESC: REPLACEMENT NORTH WING WATER HEATER	2002			10			117	41
42	DESC: MCQUAY SUITE II	2002			10			419	42
43	DESC: CARPET INSTALLATION AND VINYL BASE I	2002	985	197	5	197		394	43
44	DESC: PATIENT LIFT	2002	1,302	130	10	130		456	44
45									45
46	DESC: RENOVATION OF HALL AND CAFETERIA	2003	8,389	559	15	559		1,398	46
47	DESC: REPLACEMENT WATER HEATER	2003	4,600	460	10	460		1,150	47
48	DESC: WATER HEATER	2003	5,030	503	10	503		1,258	48
49	DESC: WATER HEATER REPAIR	2003	156	31	5	31		78	49
50	DESC: CONDENSING UNIT	2003	7,100	710	10	710		1,775	50
51	DESC: REPLACEMENT CARPETING FOR CHAPEL	2003	3,633	727	5	727		1,817	51
52	DESC: HURD WINDOWS	2003	3,540	354	10	354		885	52
53	DESC: MAINTENANCE FOR GENERATOR	2003	1,145	229	5	229		572	53
54	DESC: DIETARY BLOWER	2003	2,575	258	10	258		644	54
55	DESC: SALVAJOR DISPOSER	2003	2,219	222	10	222		555	55
56	DESC: COMMERCIAL CEILING CLEANING	2003	575	115	5	115		230	56
57									57
58	DESC: FLAT ROOF REPAIR	2004	1,350	135	10	135		203	58
59	DESC: STRIP AND REAPPLY NEW WALLPAPER	2004	3,810	762	5	762		1,143	59
60	DESC: WATER VALVES	2004	2,200	147	15	147		220	60
61	DESC: ROOF REPAIR	2004	18,000	1,800	10	1,800		2,700	61
62	DESC: SEAL AND STRIPE PARKING LOT	2004	1,970	197	10	197		296	62
63	DESC: CATERPILLAR GENERATOR ANNUAL MAINTEN	2004	807	403	1	403		807	63
64	DESC: GENERATOR HOSES & BOLTS, EXHAUST COU	2004	1,911	382	5	382		573	64
65	DESC: GENERATOR- FLUSH COOLING SYSTEM,SEAL	2004	3,112	622	5	622		622	65
66	DESC: REPLACE RADIATOR BELTS / FLUSH AND R	2004	1,200	240	5	240		240	66
67	DESC: INSTALLATION OF AMPLIFIER & SPEAKER	2004	2,041	204	10	204		306	67
68	DESC: REPLACE WATER HEATER IN SOUTH UNIT	2004	6,700	670	10	670		1,005	68
69	DESC: WATER HEATER ON LOWER LEVEL	2004	5,330	533	10	533		533	69
70	TOTAL (lines 4 thru 69)		$ 7,075,723	$ 254,243		$ 254,243	$	$ 3,686,191	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,075,723	$ 254,243		$ 254,243	$	$ 3,686,191	1
2	DESC: H/M DOORS AND FRAMES	2005	1,481	37	20	74	37	37	2
3	DESC: REPAIR BROKEN SPRINKLER SYSTEM LINE	2005	1,530	153	5	306	153	153	3
4	DESC: DEMOLITION & DRYWALL	2005	2,841	142	10	284	142	142	4
5	DESC: REPLACE AIR COMPRESSOR	2005	1,984	83	12	165	83	83	5
6	DESC: REPLACE BREATHER, HOSES, AMPMETER, A	2005	1,462	104	7	209	104	104	6
7	DESC: DOOR CLOSURES	2005	1,772	89	10	177	89	89	7
8	DESC: 4'X6' ALUMINUM FRAMED MAGNETIC WHITE	2005	785	39	10	79	39	39	8
9	DESC: V14 SOLAR PROTECTIVE FILM APPLIED TO	2005	598	60	5	120	60	60	9
10	DESC: V14 SOLAR PROTECTIVE FIL 15 PANES WE	2005	582	29	10	58	29	29	10
11	DESC: 3 CRANK HURD WINDOWS	2005	5,745	287	10	575	287	287	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,094,503	$ 255,266		$ 256,289	$ 1,023	$ 3,687,214	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 464,056	$ 51,753	$ 51,753	$	8	$ 251,004	71
72	Current Year Purchases	221,763	12,386	25,408	13,023		25,408	72
73	Fully Depreciated Assets	506,106					506,106	73
74	Home office allocation		94,746	94,746				74
75	TOTALS	$ 1,191,925	$ 158,885	$ 171,907	$ 13,023		$ 782,517	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transport	MINI-VAN	1998	$ 43,500	$	$	$	5	$ 43,500	76
77	Maintenance	F150 FORD W SNOWPLOW	1999	23,172				3	23,172	77
78										78
79										79
80	TOTALS			$ 66,672	$	$	$		$ 66,672	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,998,453	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 414,151	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 428,196	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,046	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,536,404	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Home office allocation				19,310			5
6								6
7	TOTAL				$ 19,310 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO
16. Rental Amount for movable equipment: $ 200,307 Description: Nursing - $190,284.43, Activities - $122.34, Plant Eng - $1,477.24, Admin - $7,400.11, Home office - $1,023
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	$	8,298	$ 433,130	$	8,298	$ 433,130	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		870	45,433		870	45,433	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		8,647	451,362		8,647	451,362	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				1,003,927		1,003,927	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	17,815	$ 929,925	$ 1,003,927	17,815	$ 1,933,852	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Provena St Anne Center **#** 0041737 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,947,364	$	1
2	Cash-Patient Deposits	102,762		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,022,174		3
4	Supply Inventory (priced at)	562,029		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,455		6
7	Other Prepaid Expenses	234,588		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 19,922,372	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,323,187		12
13	Land	6,872,845		13
14	Buildings, at Historical Cost	79,429,531		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	15,136,519		16
17	Accumulated Depreciation (book methods)	(44,514,067)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	133,848		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 65,381,863	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 85,304,235	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,028,501	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,196,854		28
29	Short-Term Notes Payable	35,066		29
30	Accrued Salaries Payable	2,281,363		30
31	Accrued Taxes Payable (excluding real estate taxes)	52,968		31
32	Accrued Real Estate Taxes(Sch.IX-B)	222,071		32
33	Accrued Interest Payable	26,274		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	542,408		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,385,505	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,329,784		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	219,687		42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	616,044		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,165,515	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,551,020	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 74,753,215	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 85,304,235	$	48

***(See instructions.)**

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 72,625,309	1
2	Restatements (describe):		2
3	**FAS47 Change in accounting principal**	(271,871)	3
4	**Adj. To Reconcile Consolidated Equity and Consolidated**	1,299,153	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 73,652,591	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,070,977	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	(40,261)	9
10	Stock Options Exercised		10
11	Contributions and Grants	240,328	11
12	Expenditures for Specific Purposes	(170,420)	12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,100,624	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 74,753,215	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,583,468	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,583,468	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,678,575	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,678,575	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,228	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	94,510	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,333	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 109,071	23
	D. Non-Operating Revenue		
24	Contributions	106,624	24
25	Interest and Other Investment Income***	10,115	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 116,739	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	272,499	28
28a	Misc. Income	35,199	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 307,698	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,795,551	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,583,382	31
32	Health Care	5,894,147	32
33	General Administration	2,818,043	33
	B. Capital Expense		
34	Ownership	326,804	34
	C. Ancillary Expense		
35	Special Cost Centers	1,003,927	35
36	Provider Participation Fee	98,271	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,724,574	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,070,977	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,070,977	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,040	2,080	$ 82,700	$ 39.76	1
2	Assistant Director of Nursing	2,040	2,080	63,363	30.46	2
3	Registered Nurses	29,164	31,223	797,529	25.54	3
4	Licensed Practical Nurses	51,789	55,581	1,222,003	21.99	4
5	CNAs & Orderlies	135,318	144,986	1,690,648	11.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,675	9,587	133,591	13.93	8
9	Activity Director	1,978	2,082	29,735	14.28	9
10	Activity Assistants	6,924	7,295	71,602	9.82	10
11	Social Service Workers	6,001	6,388	102,653	16.07	11
12	Dietician	3,905	4,104	76,041	18.53	12
13	Food Service Supervisor	2,010	2,413	43,105	17.86	13
14	Head Cook	8,458	9,345	115,991	12.41	14
15	Cook Helpers/Assistants	23,085	23,900	174,017	7.28	15
16	Dishwashers					16
17	Maintenance Workers	7,844	8,499	128,207	15.08	17
18	Housekeepers	14,239	15,627	139,797	8.95	18
19	Laundry	2,237	2,713	20,849	7.68	19
20	Administrator	1,832	2,080	95,205	45.77	20
21	Assistant Administrator	1,968	2,080	52,752	25.36	21
22	Other Administrative	1,992	2,080	34,596	16.63	22
23	Office Manager	2,004	2,080	37,632	18.09	23
24	Clerical	6,479	6,944	116,571	16.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Pastoral Care	2,092	2,260	38,589	17.07	33
34	TOTAL (lines 1 - 33)	322,074	345,427	$ 5,267,176 *	$ 15.25	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	532	$ 27,666	1,3	35
36	Medical Director	$1600/mth	19,200	9,3	36
37	Medical Records Consultant	32	2,369	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,524	11,3	44
45	Social Service Consultant	6	354	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	617	$ 52,113		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	641	$ 27,448	10,3	50
51	Licensed Practical Nurses	1,730	63,786	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,371	$ 91,234		53

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janelle Chadwick	Admnistrator	0	$ 95,205
Administrative Staff	Asst Administrator	0	52,752
Administrative Staff	Office Manager	0	37,632
Administrative Staff	Human Resources	0	34,596
Administrative Staff	Receptionist	0	51,657
Administrative Staff	Admin Asst	0	32,722
Administrative Staff	Admissions	0	32,192
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 336,756

B. Administrative - Other

Description	Amount
Corp Service Fee	$ 145,200
Corp Service IS Fee	99,600
Mgmt Fee	432,000
Mgmt Fee Interest	198,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 874,800
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 27,776
Survey & Analytical Tools	Various	13,053
Transportation	Various	7,154
Gift Shop	Various	6,600
Shredding	Various	517
Background Checks	Various	1,000
Outsourced Services	Various	1,992
Collection Expense	Various	2,171
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 60,263

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,800
Unemployment Compensation Insurance	40,030
FICA Taxes	379,323
Employee Health Insurance	343,133
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	22,231
Pension	130,655
Employee Recognition	3,142
Executive Benefits	5,022
Employee Screening	12,226
Home Office Allocation	151,287
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,151,849

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 106)	
Employee Recruitment	31,065
Dues & Subscription	11,086
Advertising & Public Relations	71,252
Home Office Allocation	11,503
Less: Public Relations Expense	( )
Non-allowable advertising	(68,457)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 56,449

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	17,675
Seminar Expense	
Home Office Allocation	7,198
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,873

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena St Anne Center # 0041737 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Provena St Anne Center # 0041737 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **7783 - Life Service Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **179**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **66,509** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **98,271**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **No** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not issued yet**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.